

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 08/22/2011	
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LANE ELWOOD, IN46036			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/22/11</p> <p>Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Parkview Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 92 and had a</p>			K0000	<p>Submission of this plan of correction shall not constitute or be construed as an admission by Community Parkview Care Center the allegations contained in this survey report are accurate or reflect accurately the provision of care and service to the residents at Community Parkview Care Center. The facility requests the following plan of correction be considered its allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0017 SS=E	<p>census of 81 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/26/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for</p>			K0017	<p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. No residents were affected. All residents are safe.*HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT</p>		09/21/2011

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	<p>patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 2 residents observed lounging by the front Reception office as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 at 11:15 a.m. with the Maintenance Supervisor, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: The sliding glass doors installed at the front entrance Reception office were not self closing and were open to the front entrance corridor. The Reception office did not have direct supervision by facility staff from a continuously staffed area such</p>				<p>PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have the potential to be affected. Elwood Fire Equipment has included a smoke detector in the office mentioned and it is hooked into the fire system to assure there are no problems.*WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. All areas of open use were checked to assure they have smoke detectors. The Maintenance director will check the placement and the operation of the smoke detector on a monthly basis to assure it is functioning properly. *HOW THE CORRECTIVE WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR. The Maintenance director will check the placement and the operation of the smoke detector on a monthly basis to assure it is functioning properly. The results of these checks will be discussed during the quarterly QA meeting with the Medical Director.</p>		

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K0027 SS=E	as a nurses' station. Based on interview on 08/22/11 at 11:20 a.m. with the Maintenance Supervisor, it was acknowledged the aforementioned room was open to the corridor without supervision from the nurse's station and was not protected by automatic smoke detection. 3.1-19(b)						
	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors self closed when released from it's magnetic hold. This deficient practice could affect 5 residents observed in the Main Dining room as well as visitors and staff. Findings include: Based on observation on 08/22/11 at 2:55			K0027	*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. No residents were affected. No residents were around the door.*HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have		09/21/2011

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K0054 SS=E	<p>p.m. with the Maintenance Supervisor, the set of smoke barrier doors leading into the Main Dining room on the north end of the building would not self close as a pair because the east side smoke door dragged on the floor immediately upon release from it's magnetic hold. Based on interview on 08/22/11 at 2:59 p.m. with the Maintenance Supervisor, it was acknowledged the east door of the set of doors were smoke barrier doors, dragged on the floor and would not close when released from it's magnetic hold.</p> <p>3.1-19(b)</p>				<p>the potential to be affected. The door has been repaired and will now shut totally and no longer drags on the floor. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. The Maintenance Director will check that the doors close properly during his routine checks when the alarm is activated. He will be responsible to assure the doors do not scrape on the floor.*HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Director will keep a log of his monthly checks with his preventative maintenance books. The results of his audits will be discussed during the quarterly QA meetings with the Medical Director.</p>		
	<p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 smoke detectors in the Main Dining room, 2 of 5 smoke detectors on 200 hall and 3 of 6 smoke detectors on 300 hall were installed in a location which would allow the smoke detector to function to its</p>			K0054	<p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. No residents were affected. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME</p>		09/21/2011

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	<p>fullest capability. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 4 residents observed in the Main Dining room, 33 residents on 200 hall and 39 residents on 300 hall as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 during the tour between 1:33 p.m. and 2:15 p.m., with the Maintenance Supervisor, the following smoke detectors were within two feet of an air supply duct:</p> <ul style="list-style-type: none"> a. The north and south smoke detectors on the exit side of the Main Dining room b. The smoke detectors next to rooms 200 and 204 on 200 hall c. The smoke detectors next to rooms 302, 309 and 315 on 300 hall <p>Based on interview on 08/22/11 concurrent with each observation, it was acknowledged by the Maintenance Supervisor the aforementioned smoke detectors were installed within two feet of an air supply duct in the ceiling which would not allow the smoke detector to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p>				<p>DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents could be affected. The smoke detectors have been moved to assure there is at least 3 feet between them and the air vents. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. The smoke detectors have been moved to assure there is at least 3 feet between them and the air vents. The Maintenance Director will be responsible to assure that he monitors the placement of the smoke detectors and that there is never any less than 3 feet between them and the air vents. *HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Director will monitor by checking all smoke detectors quarterly to assure there is nothing within 3 feet of them. The results of these checks will be discussed during the quarterly QA meeting with the Medical Director.</p>		

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K0062 SS=C	<p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 4 gauges for the sprinkler system were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 at 2:18 p.m. with the Maintenance Supervisor, one pressure gauge on the sprinkler riser system located in the Mechanical room on 100 hall had a manufacturer's date which was indistinct and not decipherable. Based on Sprinkler Inspection Records</p>			K0062	<p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. No residents were affected. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have the potential to be affected. All pressure gauges have been checked. The gauge that had a manufacturer's date which was indistinct and not decipherable has been changed and is now visible. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. All pressure gauges will be changed and calibrated every 5 years per regulations by Elwood Fire Equipment Company. The Maintenance Director will check</p>		09/21/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2011

FORM APPROVED

OMB NO. 0938-0391

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	review on 08/22/11 at 3:21 p.m., documentation did not indicate the sprinkler system gauge had been calibrated or the date of installation. Based on interview on 08/22/11 at 2:25 p.m. the Maintenance Supervisor, it was acknowledged the pressure gauge was corroded and rusty and the manufacturer's date could not be read. 3.1-19(b)				the gauges every quarter to assure that the readings are legible and clear. *HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The Maintenance Director will monitor by checking all gauges quarterly to assure they are legible and clear. The results of these checks will be discussed during the quarterly QA meeting with the Medical Director.		